

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036828

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED SEP 27 1963

Primary Registration District No. 42965683 Registrar's No. 19

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Linn | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Linn | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR Browning Rural | | c. CITY OR TOWN Browning Rural | |
| Length of stay in lb | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Farm Home | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Fessie T. Minor | | 4. DATE OF DEATH Month Sept Day 22 Year 63 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 8/23/03 |
| 9. AGE (last birthday) 60 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (City and state or country) Missouri | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Grant E. Minor | | 13b. MOTHER'S MAIDEN NAME Alfie Bivins | |
| 14. NAME OF HUSBAND OR WIFE Hallie G. Minor | | Address | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Hallie G. Minor | | Address Browning | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) S.O.A. Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Acute Coronary occlusion DUE TO (c) Chronic heart disease & Mitral Insufficiency 10 yrs. | | INTERVAL BETWEEN ONSET AND DEATH Immediate | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY Mo. STATE | |
| 21. I attended the deceased from S.O.A. 8:30 A to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE H. H. Bohm M.D. | | 22b. ADDRESS Brookfield Mo. | |
| 22c. DATE SIGNED 9/23/63 | | (State) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 9/24/63 | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Mem Gard | |
| 23d. LOCATION (City; town, or county) Brookfield Mo. | | | |
| 24. FUNERAL DIRECTOR Wade Funeral Home | | 25. DATE RECD. BY LOCAL REG. 9/24/1963 | |
| ADDRESS Browning | | 26. REGISTRAR'S SIGNATURE Louvenia M. Mace | |

USE BLACK INK
OR
TYPEWRITER RIBBON

88-0000-0000

OCT 11 1963

OCT 10 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Gerald J. Wade

Licensed Embalmer No: 4172

P. O. Address Brown

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.